DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

File

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99 — 009

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 1999

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.300-321

7. FEDERAL BUDGET IMPACT:
a. FFY 1999 $ 0 *
b. FFY 2000 $ (4,000) in Thousands **

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B(1), pp.1,9-23 and Exhibit 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B(1), pp. 9-28

10. SUBJECT OF AMENDMENT:
Acute Hospital Outpatient Payment System

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark E. Reynolds (per KS)

13. TYPED NAME:
Mark E. Reynolds

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
September 30, 1999

16. RETURN TO:
Bridget Landers
Coordinator for the State Plan
Division of Medical Assistance
600 Washington St.,
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 30, 1999

18. DATE APPROVED:
June 6, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 1999

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Ronald Preston

22. TITLE:
Associate Regional Administrator for Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

* No expected increase in expenditures in FY99

File

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Non-Institutional Reimbursement

Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

I: OVERVIEW

On August 7, 1998, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued the MassHealth program's seventh Request for Application (RFA) to solicit applications from eligible, in-state acute hospitals which seek to participate as MassHealth providers of acute hospital services. The goal of the RFA was to enter into contracts with all eligible, acute hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing MassHealth members with the same level of clinical services as is currently provided by those hospitals and their hospital-licensed health centers. In-state acute hospitals which: (1) operate under a hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/ surgical, intensive care, coronary care, burn, pediatric, pediatric intensive care, maternal (obstetrics) or neonatal intensive care beds, as determined by DPH; and (4) currently utilize more than 50% of their beds as such, as determined by the Division, are eligible to apply for a contract pursuant to the RFA. All eligible acute hospitals are participating providers.

The RFA was amended effective October 1, 1998 to update the wage area adjustment to reflect the most recent HCFA wage index information (1995), and on July 1, 1999 to implement the second phase of Ambulatory Patient Groups (APGs).

IV: REIMBURSEMENT SYSTEM

A. Outpatient Services

Rates for outpatient services covered under a contract between the acute hospital and the MH/SAP contractor that are provided to Medicaid patients eligible for or assigned to the Division's MH/SAP contractor shall be governed by terms agreed upon between the acute hospital and the MH/SAP contractor.

Hospitals will not be reimbursed on an outpatient basis when an inpatient admission to the same hospital, on the same date of service, occurs following provision of outpatient services. Reimbursement for such outpatient services will be provided through the acute hospital inpatient payment system only. See State Plan Attachment 4.19A.

The following methodology will apply to outpatient services when those services are rendered at hospital outpatient departments including emergency departments, hospital-licensed health centers (HLHCs), and school-based health centers (SBHCs). To be reimbursed for any services provided at a site other than the hospital outpatient department or SBHC, (including but not limited to HLHCs), the hospital must enroll that site with the Division as an appropriate provider type. If the site is not recognized by the Division as a provider type, no service provided to a member at that site is reimbursable.

Hospitals will be reimbursed only for hospital services specified in Subchapter 6 of the Acute Outpatient Hospital Manual. Hospitals will be reimbursed for physician services specified in Subchapter 6 of the Acute Outpatient Hospital Manual and only in accordance with Section IV.A.1.

1. Physician Payments

a. A hospital may only receive reimbursement for physician services provided by hospital-based physicians or hospital-based entities to Medicaid members. The hospital must claim payment in accordance with, and subject to 1) the Physician Regulations at 130 CMR 433.000 et seq., 2) the Acute Outpatient Hospital Regulations at 130 CMR 410.000 et seq.; and the payment rules as set forth in Section IV.

b. Except as otherwise provided in Section IV.A.1.c below, such reimbursement shall be the lower of i) the fee in the most current promulgation of the DHCFP fees as established in 114.3 CMR 16.00, 17.00 and 18.00; ii) the hospital's usual and customary charge for physician fees; or; iii) the hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners

other than hospital-based physicians or hospital-based entities as defined in Section II.

c. For physician services provided by a hospital-based physician or hospital-based entity for an outpatient service included on the site-of-service list, the hospital will be reimbursed at the lower of 1) 79% of the fee established in the DHCFP Regulations at 114.CMR 16.00, 17.00 and 18.00; 2) 100% of the hospital's usual and customary charge for physician fees; or 3) 100% of the hospital's actual charge submitted.

d. Hospitals will be reimbursed for physician services only if the hospital-based physician or a physician providing services on behalf of a hospital-based entity took an active patient care role, as opposed to a supervisory role, in providing the outpatient service(s) on the billed date(s) of service.

e. Physician services provided by residents and interns are not reimbursable separately.

f. Hospitals will not be reimbursed for physician services if those services are (1) provided by a community-based physician or community-based entity; or (2) are related to the provision of laboratory, ancillary, recovery room, off-site radiation and oncology treatment center, audiology dispensing, anbulance, psychiatric day treatment, and certain dental services as further described in Section IV.A below.

g. In order to qualify for reimbursement for physician services provided during the provision of observation services, the reasons for the observation services, the start and stop time of the observation services, and the name of the physician ordering the observation services, must be documented in the member's medical record.

h. When a hospital-based physician or hospital-based entity provides physician services during a radiology service, the hospital may, when the service is not reimbursed with a global fee that covers both technical and professional portions, be reimbursed for such physician services in accordance with Section IV.A.1.

2. <u>Outpatient Hospital Department and Emergency Department Services Payment Limitations</u>

a. Payment Limitations on a Hospital Outpatient and Emergency Department Services Preceding an Admission

Hospitals will not be reimbursed for hospital outpatient department or emergency department services when an inpatient admission to the same hospital, on the same date of service, occurs following the hospital outpatient department or emergency department visit; provided, however, that this payment limitation does not apply where an admission involving a one day length of stay occurs on the same day following a significant procedure.

b. Payment Limitations on Emergency Department Services

Hospitals will not be reimbursed for Emergency Department services, if such services are for: (i) primary care services provided to any member; (ii) urgent care services provided to a member enrolled in the PCCP, in an emergency room between 8:00 A.M. and 9:59 P.M., unless so authorized by the member's PCC or unless the member's PCC is not available for authorization; and, (iii) urgent care services provided in an E.D. to a member not enrolled in the PCCP, when the hospital determines that the member has the opportunity to receive urgent care elsewhere (e.g. the member's regular physician, an accessible Community Health Center, or the hospital's outpatient clinic).

All members presenting in the emergency department must be screened in the emergency department in accordance with 42 U.S.C. 1395dd et seq. Hospitals will be reimbursed for such screening services either through a) the appropriate APG payment, or b) through the Emergency Department Screening Fee (see Section IV.A.4), whichever is applicable.

3. **Ambulatory Patient Groups**

Except for those outpatient services specified in Sections IV, A, 1, 2, and 4-14, outpatient hospital services provided in a hospital or Hospital Licensed Health Center on or after July 1, 1999, will be paid under the Ambulatory Patient Group (APG) system. For a particular provision of services, the hospital will be paid a flat rate that depends on the procedures performed and the patient's diagnoses. For individual services that require extraordinary use of resources, hospitals may be able to receive outlier payments.

a. Scope

As defined by the Division [and outlined in detail in Exhibit A to Attachment 4.19B(1)], APGs consist of 290 groups of outpatient services and procedures, categorized based on CPT and HCPCS Level II codes, that are covered by the Division, as well as local procedure codes established by the Division. The codes that comprise each APG are consistent with the latest available update of

3M Health Information Systems' Ambulatory Patient Grouper, Version 2.0, as modified by the Division.

b. APG Rate Development

The rate for each APG is the product of each APG's relative weight, and a conversion factor, defined as follows.

1. *Relative Weights*: APG weights were set from all paid MassHealth in-state acute outpatient hospital and Hospital Licensed Health Center claims for hospital rate year 1996 (October 1, 1995 to September 30, 1996). The claims were bundled into each APG. Each APG's weight was calculated using MassHealth data, such that it reflects the experience of Massachusetts hospitals in service MassHealth members. For each APG, the relative weight is the quotient of:

$$\frac{\text{Average Estimated Hospital Cost for All Visits for the APG}}{\text{Average Estimated Hospital Cost for All Visits}}$$

   Weights were set based on an untrimmed paid claims data from the 1996 rate year. Medicare crossover claims were excluded from the calculation. Costs were estimated by multiplying submitted charges by hospital-specific cost to charge ratios.

2. Conversion Factors: The Baseline Conversion Factor is the average rate year 1996 MassHealth outpatient payment per visit, multiplied by an outlier adjustment factor of 95%, a coding refinement factor of 97%, a 95% efficiency discount, and a 99.5% adjustment for PCC enhancement fees. The conversion factor was multiplied by 2.38% to reflect prices changes between FY96 and FY97, by 2.14% to reflect price changes between FY97 and FY98, and by 1.9% to reflect price changes between FY98 and FY99. Wherein this 1.9% factor is applied to the claims with dates of service of July 1, 1999 through September 30, 1999, the factor was adjusted to 7.6%. The baseline conversion factor was multiplied by 1.12 to further adjust for the consolidation, packaging and discounting which occurs in the APG reimbursement methodology.

   Based upon the MassHealth service mix index, derived from the sum of APG relative weights taken from a seven week sampling of paid FY1999 claims, hospitals were ranked from highest to lowest in terms of net revenue change under the APG methodology. The baseline factor was multiplied by 1.10 for the top ten (10) hospitals with an estimated loss of $50,000 or more, yielding

a Transitional Conversion Factor of $125.42. The baseline factor was multiplied by 0.95 to arrive at a Standard Conversion factor of $108.32, which applies to all other hospitals and any new providers.

c. APG Categories:

APGs are categorized into five distinct categories. These categories are used as part of the payment methodology:

1. *Significant Procedure APGs*: Includes the following APGs: 001-055, -071-083, 093-138, 151-192, 194-250, 253-255, 281

2. *Therapy APGs*: Includes the following APGs: 057, 084, 091, 092, 139, 140, 193, 251, 252, 271-273, 282-289

3. *Medical APGs*: Includes APGs 431 through 721.

4. *Ancillary APGs*: Includes APGs 301 through 422.

5. *Error APGs*: Includes APGs 992-999. These APGs include coding errors and ungroupable claims, and are therefore not payable under the APG system.

d. Significant Procedure APGs:

1. A three day period called a "window" is used to determine payment of Significant Procedure APGs. This window includes the day of, the day before, and the day after the occurrence of a service assigned a Significant Procedure APG.

2. No separate payment is made for any Medical or Ancillary APGs occurring during the three day window, except as provided below for chemotherapy drug APGs.

e. Multiple APGs:

A single visit may have more than one APG assigned. Payment for a single visit with multiple APGs is as follows:

1. *Significant Procedure APGs*:

    a. When more than one significant procedure APG is assigned during a

three-day window, the significant procedure APG with the highest relative weight is paid at 100%, with the exception of chemotherapy drug APGs (APGs 391-395), which are paid at 100%.

b. Additional significant procedures are either paid at 50% of the APG rate ('discounted'), or are 'consolidated'. Consolidated APGs are assigned when a simple procedure is an integral part of a more complex procedure. Payment for the simple procedure is consolidated into the payment for the more complex procedure, and no separate payment is made for the simple procedure.

c. If a Significant Procedure APG and a Therapy APG are assigned during the three-day window, the highest weighted Significant Procedure or Therapy APG is paid at 100% and any additional APGs are paid at 50%.

No separate payment is made for any Medical and/or Ancillary APGs occurring during the three-day window, with the exception of chemotherapy drug APGs (APGs 391-395), which are paid at 100%.

2. *Therapy APGs*

When more than one Therapy APG is assigned, the highest weighted Therapy APG is paid at 100%, and additional Therapy APGs are discounted and paid at 50%. No separate payment is made for additional Medical and/or Ancillary APGs, with the exception of chemotherapy drug APGs (APGs 391-395), which are paid at 100%.

3. *Medical APGs*

When more than one Medical APG is assigned, the Medical APG with the highest weight is paid at 100%. No separate payment is made for additional Medical and/or Ancillary APGs.

4. *Ancillary Visits*

When more than one ancillary APG is assigned, the Ancillary APG with the highest weight is paid at 100%. Additional Ancillary APGs are discounted and paid at 50%.

f. Outlier Payments:

A visit or visits within a three day window for a Significant Procedure may qualify for outlier payments if the difference between the APG payment and 45% of the hospital's charges exceed the "outlier threshold" of $1450.00. The APG payment in such circumstances is the sum of all payments for all APGs assigned for that visit. The outlier payment will equal the difference of the estimated hospital cost and the APG payment. The estimated hospital cost is the product of the billed charges and the hospital-specific cost-to-charge ratio. The hospital-specific cost-to-charge ratio was derived by taking total ancillary costs including capital from the FY93 RSC-403 and by dividing by the total ancillary revenues from the FY93 RSC-403.

4. Emergency Department Screening Fee

The following Emergency Department Screening fee payments are excluded from the APG methodology. Hospitals will be separately reimbursed for emergency department screening as follows:

a. Conditions of Reimbursement

Hospitals will be reimbursed a separate screening fee only when a hospital-based physician or a physician providing services on behalf of a hospital-based entity provides screening services to a MassHealth member in a hospital Emergency Department as follows:

i. the Emergency Department physician determines at any hour that a member requires elective or primary care;

ii. the Emergency Department physician determines between the hours of 8:00 a.m. and 9:59 p.m. that a member enrolled in the Division's PCCP requires urgent care and the PCC declines to authorize emergency room services; or

iii. the Emergency Department physician determines that a member not enrolled in the Division's PCCP requires urgent care, and the hospital determines that the member has the opportunity to receive this care elsewhere.

b. Rate Methodology

The Emergency Department Screening Fee is based on the average cost per screening visit and the rate for a comprehensive physician's office visit. The bundled rate includes components for professional services, ancillary services

required to determine the acuity of the patient's condition, educational instruction on the use of the Division's PCC/managed care system for members enrolled in the PCCP, educational instruction on accessing primary care/urgent services in community health centers, hospital outpatient clinics, and physicians for members not enrolled in the PCCP, related educational materials and administrative duties. The Emergency Department Screening Fee is the exclusive reimbursement for services provided under the circumstances set forth in Section IV.A.4.a.

No additional reimbursement, including but not limited to, ancillary services, professional services, and Emergency Department visit payments applies.

5. The Norplant System

a. Payment for Norplant Services

Hospitals will be reimbursed according to both the Physician Regulations in 130 CMR 433.000 and the fees established in the most recent promulgation of the DHCFP's Family Planning Regulations (114.3 CMR 12.00), when a hospital-based physician or a physician on behalf of a hospital-based entity inserts, removes, or removes and reinserts the Norplant System of Contraception. The hospital may only bill for the hospital-based physician payment as the fee (according to the DHCFP's Family Planning Regulations at 144.3 CMR 12.00) represents payment in full for all services associated with the Norplant System of Contraception.

b. Physician Payment

Hospitals will be reimbursed for hospital-based physicians or hospital-based entities as set forth in Section IV.A.1 above.

6. Off-Site Radiation and Oncology Treatment Centers

Hospitals that provide radiation and oncology treatment services through an Off-Site Radiation and Oncology Treatment Center will be reimbursed according to the lower of the fee schedule or the hospital's usual and customary charge. Only those services listed by the Division are reimbursable at the Off-Site Radiation and Oncology Treatment Center. These rates represent payment in full for services and neither the hospital or physician is entitled to any additional reimbursement (e.g., hospital outpatient

department visit payments, APGs, physician payments).

To be reimbursed for any services provided at an Off-Site Radiation and Oncology Treatment Center, the hospital must enroll that site with the Division as a provider. If the site is not recognized by the Division as an Off-Site radiation and Oncology Treatment Center provider, no service provided to a member at that site is reimbursable.

7. Audiology Dispensing

a. Payment for Audiology Dispensing Services

Hospitals will be reimbursed for the dispensing of hearing aids only by a hospital-based audiologist according to the audiologist regulations at 130 CMR 426.00 et seq., and at the lower of the most current of the DHCFP fees as established in 114.3 CMR 23.00, or the hospital's usual and customary charge.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of audiology dispensing services.

8. Ambulance Services

a. Payment for Ambulance Services

Ambulance services shall be classified as either air or ground ambulance services. Ground ambulance services shall be reimbursed by the Division subject to all regulations pursuant to 130 CMR 407.000 et seq., in the Transportation Manual. Payment shall be the lower of the rates established by the DHCFP, under 114.3 CMR 27.00, et seq., or the hospital's usual and customary charge.

If the costs of ground ambulance services were included by the hospital in the FY90 cost base for FY90 outpatient department services, no additional reimbursement for ground service ambulance may be billed.

In order to receive reimbursement for air ambulance services, providers must have separate contracts with the Division for such services.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of ambulance services.

9. Psychiatric Day Treatment Program

a. Payment for Psychiatric Day Treatment Services

For services to members who are not enrolled in the MH/SAP, the Division will reimburse acute hospital outpatient department psychiatric day treatment programs which are enrolled with the Division as such according to the regulations as set forth in the Psychiatric Day Treatment Program regulations at 130 CMR 417.401 - 440, at the lower of rates promulgated by the DHCFP, as established in 114.3 CMR 7.03, or the hospital's usual and customary charge.

Hospitals may not bill for psychiatric day treatment services in addition to outpatient clinic mental health services if both were delivered on the same day.

In order to qualify for reimbursement, Psychiatric Day Treatment Programs must be certified by the Division as described in 130 CMR 417.405.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of Psychiatric Day Treatment Program services.

10. Dental Services

a. Payment for Dental Services

All covered dental services will be reimbursed by the Division, subject to all regulations at 130 CMR 420.000 et seq., in the Dental Manual, at the lower of the most current rates promulgated by the DHCFP, as established in 114.3 CMR 14.00 et seq., or the hospital's usual and customary charge, except when the conditions in 130 CMR 420.429(A) or (D) apply. When these conditions apply, the Division will reimburse the hospital according to Section IV.A.3.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of dental services, except when the conditions in 130 CMR 420.429(A) or (D) apply. Under those circumstances, in addition to the APG payment under Section IV.A.3, when a hospital-based physician or hospital-based entity provides physician services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

11. Adult Day Health

a. Payment for Adult Day Health Services

The Division will reimburse acute hospital outpatient departments as set forth in the Adult Day Health regulations at 130 CMR 404.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 10.00 et seq., or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Adult Day Health service payment, when a hospital-based physician or a hospital-based entity provides physician services during Adult Day Health Services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

12. Early Intervention Program

a. Payment for Early Intervention Services

The Division will reimburse acute hospital outpatient departments as set forth in the Early Intervention Program regulations at 130 CMR 440.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 49.00 et seq., or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Early Intervention Service Payment, when a hospital-based physician or hospital-based entity provides physician services during Early Intervention Services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.